Professional Services

This section contains payment policy information for professional services. Many of the policies contain information previously published in *Provider Bulletins*.

In addition to the policies outlined in this section, all providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules, Provider Bulletins,* and *Provider Updates*. If there are any services, procedures, or text contained in the CPT® and HCPCS coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies apply (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811.

PROFESSIONAL SERVICES TABLE OF CONTENTS

PROFESSIONAL SERVICES TABLE OF CONTENTS

GENERAL INFORMATION

COVERED SERVICES

The department makes general policy decisions, called medical coverage decisions, to ensure quality of care and prompt treatment of workers. Medical coverage decisions include or exclude a specific health care service as a covered benefit.

No payment will be made for non-covered codes. Non-covered codes are listed with "Not Covered" in the dollar value columns in the Professional Services Fee Schedule. They are also listed in Appendix D at the end of this document.

For more information on coverage decisions and covered services, refer to WAC 296-20 sections -01505, -02700 through -02850, -03002 and -1102.

UNITS OF SERVICE

Payment for billing codes that do not specify a time increment or unit of measure is limited to one unit per day. For example, only one unit is payable for CPT® code 97022, whirlpool therapy, regardless of how long the therapy lasts.

UNLISTED CODES

A covered service or procedure may be provided that does not have a specific code or payment level listed in the fee schedules. When reporting such a service, the appropriate unlisted procedure code may be used and a special report is required as supporting documentation. No additional payment is made for the supporting documentation. Refer to WAC 296-20 of the Washington Administrative Code (including the definition section), and to the fee schedules for additional information.

WASHINGTON RBRVS PAYMENT SYSTEM AND POLICIES

The department uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. Services priced according to the RBRVS fee schedule have a fee schedule indicator of "R" in the Professional Services Fee Schedule.

BASIS FOR CALCULATING RBRVS PAYMENT LEVELS

RBRVS fee schedule allowances are based on relative value units (RVUs), geographic adjustment factors for Washington State, and a conversion factor. The three state agencies (the Department of Labor and Industries, the Health Care Authority and the Department of Social and Health Services) use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

The primary source for the current RVUs is the 2002 Medicare Physician Fee Schedule Database (MPFSDB), which was published by the Centers for Medicare and Medicaid Services (CMS) in the November 1, 2001 *Federal Register*. The *Federal Register* can be accessed online from the "Laws and Regulations" link on CMS's website or can be purchased from the U.S. Government in hard copy, microfiche, or disc formats. The *Federal Register* can be ordered from the following addresses:

Superintendent of Documents PO Box 371954 Pittsburgh, PA 15250-7954	or	U.S. Government Bookstore 915 2nd Avenue Seattle, WA 98174

Under CMS's approach, relative values are assigned to each procedure based on the resources required to perform the procedure, including the work, practice expense, and liability insurance (malpractice expense). The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State. The Washington State geographic adjustment factors for July 1, 2002 are: 98.9% of the work component RVU, 101.1% of the practice expense RVU, and 78.8% of the malpractice RVU.

To calculate the department's maximum fee for each procedure:

1) Multiply each RVU component by the corresponding geographic adjustment factor,
2) Sum the geographically adjusted RVU components and round the result to the nearest hundredth,
3) Multiply the rounded sum by the department's RBRVS conversion factor (published in WAC 296-20-135) and round to the nearest penny.

The department's maximum fees are published as dollar values in the Professional Services Fee Schedule.

SITE OF SERVICE PAYMENT DIFFERENTIAL

The site of service differential is based on CMS's payment policy and establishes distinct maximum fees for services performed in facility and non-facility settings. The department will pay professional services at the RBRVS rates for facility and non-facility settings based on where the service was performed. Therefore, it is important to **include a valid two-digit place of service code on your bill**.

The department's maximum fees for facility and non-facility settings are published in the Professional Services Fee Schedule.

Services Paid at the RBRVS Rate for Facility Settings

When services are performed in a facility setting, the department makes two payments, one to the professional provider and another to the facility. The payment to the facility includes resource costs such as labor, medical supplies and medical equipment. To avoid duplicate payment of resource costs, these costs are excluded from the RBRVS rates for facility settings.

Professional services will be paid at the RBRVS rate for facility settings when the department also makes a payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for facility settings:

Place of Service Code	Place of Service Description
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room- hospital
24	Ambulatory surgery center
25	Birthing Center
26	Military treatment facility
31	Skilled nursing facility
51	Inpatient psychiatric facility
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
99	Other unlisted facility
(none)	(Place of service code not supplied)

Services Paid at the RBRVS Rate for Non-Facility Settings

When services are provided in non-facility settings, the professional provider typically bears the costs of labor, medical supplies and medical equipment. These costs are included in the RBRVS rate for non-facility settings.

Professional services will be paid at the RBRVS rate for non-facility settings when the department does not make a separate payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for non-facility settings:

Place of Service Code	Place of Service Description
03	School
04	Homeless shelter
11	Office
12	Home
15	Mobile unit
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance (land)
42	Ambulance (air or water)
50	Federally qualified health center
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment center
56	Psychiatric residential treatment center
60	Mass immunization center
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Inpatient laboratory

Facilities will be paid at the RBRVS rate for non-facility settings when the department does not make a separate payment directly to the provider of the service.

Billing Tip

Remember to include a valid two-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

EVALUATION AND MANAGEMENT SERVICES (E/M)

NEW AND ESTABLISHED PATIENT

The department uses the CPT© definitions of *new* and *established* patients.

If a patient presents with a work related condition and meets the definition of a new patient in a provider's practice, then the appropriate level of a new patient E/M should be billed.

If a patient presents with a work related condition and meets the definition of an established patient in a provider's practice, then the appropriate level of established patient E/M service

should be billed, **even if the provider is treating a new work related condition for the first time.**

MEDICAL CARE IN THE HOME OR NURSING HOME

The department allows attending physicians to charge for nursing facility services (CPT® codes 99301-99313), domiciliary, rest home (e.g., boarding home), or custodial care services (CPT® codes 99321-99333) and home services (CPT® codes 99341-99350). The attending physician (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

PROLONGED EVALUATION AND MANAGEMENT

Payment of prolonged E/M (CPT® codes 99354-99357) is allowed with a maximum of three hours per day per patient. These services are payable only when another E/M code is billed on the same day using the following CMS payment criteria:

CPT® Code	Other CPT® Code(s) Required on Same Day
99354	99201-99205, 99212-99215, 99241-99245 or 99324-99350
99355	99354 *and* one of the E/M codes required for 99354
99356	99221-99223, 99231-99233, 99251-99255, 99261-99263, 99301-99303, or 99311-99313
99357	99356 *and* one of the E/M codes required for 99356

The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the provider and the patient (whether the service was continuous or not). Prolonged physician services without direct contact (CPT® codes 99358 and 99359) are bundled and are not payable in addition to other E/M codes.

A narrative report is required when billing for prolonged evaluation and management services.

PHYSICIAN STANDBY SERVICES

The department pays for physician standby services (CPT® code 99360) when all the following criteria are met:

- Another physician requested the standby service,
- The standby service involves prolonged physician attendance without direct (face-to-face) patient contact,
- The standby physician is not concurrently providing care or service to other patients during this period,
- The standby service does not result in the standby physician's performance of a procedure subject to a "surgical package," and
- Standby services of 30 minutes or more are provided.

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a *full* 30 minutes of standby was provided for each unit of service reported. Round all fractions of a 30-minute unit downward.

Justification for the physician standby service must be documented and retained in the provider's office and submitted to the department or Self-Insurer for review upon request.

A narrative report is required when billing for physician standby services.

CASE MANAGEMENT SERVICES

Team conferences (CPT® codes 99361-99362) may be payable when the attending doctor, consultant, or psychologist meets with an interdisciplinary team of health professionals, department staff, vocational rehabilitation counselors, nurse case managers, department medical consultants, Self-Insurer representatives or employers. Documentation must include a goal-oriented, time-limited treatment plan covering medical, surgical, vocational or return to work activities, or objective measures of function that allow a determination as to whether a previously created plan is effective in returning the injured worker to an appropriate level of function.

Telephone calls (CPT® codes 99371-99373) are payable only when personally made by the attending doctor, consultant or psychologist. These services are payable when discussing or coordinating care or treatment with the injured worker, department staff, vocational rehabilitation counselors, nurse case managers, department medical consultants, Self-Insurer representatives or employers. Telephone calls for authorization, resolution of billing issues, or ordering prescriptions are not payable.

Documentation for case management services (CPT® codes 99361-99373) must include:

- The date,
- The participants and their titles,
- The length of the call or visit,
- The nature of the call or visit, and
- All medical, vocational or return to work decisions made.

Psychiatrists and clinical psychologists may only bill for case management services when also providing consultation or evaluation.

PHYSICIAN CARE PLAN OVERSIGHT

The department allows separate payment for physician care plan oversight services (CPT® codes 99375, 99378 and 99380). Payment is limited to one per attending physician, per patient, per 30-day period. Care plan services (CPT® codes 99374, 99377 and 99379) of less than 30 minutes within a 30-day period are considered part of E/M services and are not separately payable.

Payment for care plan oversight to a physician providing postsurgical care during the postoperative period will be made only if the care plan oversight is documented as unrelated to the surgery, and modifier –24 is used. The attending physician (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

TELECONSULTATIONS

The department has adopted a modified version of CMS's policy on teleconsultations. Teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real-time consultation between the patient, consultant and referring provider. Telephones, faxes and electronic mail systems do not meet the definition of an interactive telecommunication system.

Coverage of Teleconsultations

Teleconsultations are covered in the same manner as face-to-face consultations (refer to WACs 296-20-045 and –051), but *in addition*, **all** of the following conditions must be met:

- The **consultant** must be a doctor as described in WAC 296-20-01002, which includes a MD, DO, ND, DPM, OD, DMD, DDS, or DC. A consulting DC must be an approved consultant with the department.
- The **referring provider** must be one of the following: MD, DO, ND, DPM, OD, DMD, DDS, DC, ARNP, PA, or PhD Clinical Psychologist.
- The patient must be present at the time of the consultation.
- The examination of the patient must be under the control of the consultant.
- The referring provider must be physically present with the patient during the consultation.
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer.
- A referring provider who is not the attending must consult with the attending provider before making the referral.

Payment of Teleconsultations

Teleconsultations are paid in a different manner than face-to-face consultations. Also, the department and Self-Insurers pay for teleconsultations in a different manner than CMS. Insurers may directly pay both consultants and referring providers for their services. Insurers will pay according to the following criteria:

- Providers (consulting and/or referring) must append a "GT" modifier to one of the appropriate codes listed in the table below.
- The amount allowable for the appropriate code is the lesser of the billed amount or 75% of the fee schedule amount.
- No separate payment will be made for the review and interpretation of the patient's medical records and/or the required report that must be submitted to the referring provider and to the department.
- No payment is allowed for telephone line charges and facility fees incurred during the teleconsultation.

The Consultant May Bill Codes:	**The Referring Provider May Bill Codes:**
CPT® codes 99241-99245	CPT® codes 99211-99215
CPT® codes 99251-99255	CPT® codes 99218-99239
CPT® codes 99261-99263	CPT® codes 99301-99313
CPT® codes 99271-99275	CPT® codes 99331-99333
CPT® codes 99241-99244 (for DCs)	CPT® codes 99347-99357
	CPT® codes 99211-99214 (for DCs)
Local codes 2130A-2134A (for NDs)	CPT® codes 90801 (for PhD Clinical Psychologists)
	Local codes 2133A-2134A (for NDs)

END STAGE RENAL DISEASE (ESRD)

The department follows CMS's policy regarding the use of E/M services along with dialysis services. E/M services (CPT® codes 99231-99233 and 99261-99263) are not payable on the same date as hospital *inpatient* dialysis (CPT® codes 90935, 90937, 90945 and 90947). These E/M services are *bundled* in the dialysis service.

Separate billing and payment for an initial hospital visit (CPT® codes 99221-99223), an initial inpatient consultation (CPT® codes 99251-99255), and a hospital discharge service (CPT®

code 99238 or 99239), will be allowed when billed on the same date as an inpatient dialysis service.

APHERESIS

The department follows CMS's policy regarding apheresis services. Separate payment for established patient office or other outpatient visits (CPT© codes 99211-99215), subsequent hospital care (CPT© codes 99231-99233), and follow-up inpatient consultations (CPT© codes 99261-99263), will not be allowed on the same date that therapeutic apheresis (CPT© code 36520) is provided.

Physicians furnishing therapeutic apheresis services may bill for the appropriate E/M visit or consultation code indicating the level of services provided rather than billing for the therapeutic apheresis services. This will permit physicians to be paid for the level of service furnished.

The time spent in apheresis management may not be counted in determining the duration of time spent in critical care services (CPT© codes 99291 and 99292). The code for therapeutic apheresis includes payment for all medical management services provided to the patient on the same date of service. Payment will be made for only one unit of CPT© code 36520 provided by the same physician, on the same date, for the same patient.

SURGERY SERVICES

GLOBAL SURGERY POLICY

Many surgeries have a follow-up period during which charges for normal postoperative care are bundled into the global surgery fee. The global surgery follow-up day period for each surgery is listed in the "Fol-Up" column in the Professional Services Fee Schedule.

Services and Supplies Included in the Global Surgery Policy

The following services and supplies are included in the global surgery follow-up day period and are considered bundled into the surgical fee:

- The operation itself.
- Preoperative visits, in or out of the hospital, beginning on the day before the surgery.
- Services by the primary surgeon, in or out of the hospital, during the postoperative period.
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; insertion, irrigation and removal of urinary catheters, cast room charges, routine peripheral IV lines, nasogastric and rectal tubes; and change and removal of tracheostomy tubes. *Casting materials are not part of the global surgery policy and are paid separately.*
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

How to Apply the Follow-Up Day Period

The follow-up day period applies to **any provider** who participated in the surgical procedure. These providers include:

- Surgeon or physician who performs any component of the surgery (e.g., the pre, intra, and/or postoperative care of the patient; identified by modifiers –56, -54, and –55)
- Assistant surgeon (identified by modifiers –80, -81, and –82)
- Two surgeons (identified by modifier –62)
- Team surgeons (identified by modifier –66)
- Anesthesiologists and CRNAs

The follow-up day period always applies to the following CPT© codes, *unless* modifier -24, -25, -57, or -79 is appropriately used:

E/M Codes		Ophthalmological Codes
99211-99215	99301-99303	92012-92014
99218-99220	99311-99316	
99231-99239	99331-99333	
99261-99263	99347-99350	
99291-99292		

Professional inpatient services (CPT© codes 99211-99223) are only payable during the follow-up day period if they are performed on an emergency basis (i.e., they are not payable for scheduled hospital admissions).

Codes that are considered *bundled* are **not payable** during the global surgery follow-up period.

PRE, INTRA, OR POSTOPERATIVE SERVICES

The department or Self-Insurer will allow separate payment when the preoperative, intraoperative or postoperative components of the surgery are performed by different physicians or providers. The appropriate modifiers (-54, -55 or -56) must be used. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

If different providers perform different components of the surgery (pre, intra, or postoperative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the patient to another physician for the postoperative care, the same global surgery policy, including the restrictions in the follow-up day period, applies to both physicians.

STARRED SURGICAL PROCEDURES

In the *Surgery* section of the CPT© book, many minor surgeries are designated by a star (*) following the procedure code.

For these starred procedures, the department follows CMS's policy to not allow payment for an E/M office visit during the global period unless:

- A documented, unrelated service is furnished during the postoperative period and modifier –24 is used, or
- The practitioner who performs the procedure is seeing the patient for the first time, in which case an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier –25 must be used. Appropriate documentation must be made in the chart describing the E/M service.

CPT® code 99025, initial surgical evaluation, is considered bundled and is not separately payable. Modifier –57, decision for surgery, is not payable with minor surgeries (e.g., starred procedures). When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation is not paid in addition to the procedure.

Modifier –57 is payable with an E/M service only when the visit results in the initial decision to perform *major* surgery.

STANDARD MULTIPLE SURGERY POLICY

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

100% of the global fee for the procedure or procedure group with the highest value according to the fee schedule

50% of the global fee for the ***second through fifth procedures*** with the next highest values, according to the fee schedule.

Procedures in excess of five require submission of documentation and individual review to determine payment amount.

When different types of surgical procedures are performed on the same patient on the same day for accepted conditions, the payment policies should always be applied in the following sequence:

- Multiple endoscopy policy for endoscopy procedures
- Other modifier policies, and finally
- Standard multiple surgery policy.

BILATERAL PROCEDURES POLICY

Bilateral surgeries should be billed as two line items. Modifier –50 should be applied to the second line item. When billing for bilateral surgeries, the two line items should be treated as one procedure. The second line item is paid at the lesser of the billed charge or 50% of the fee schedule maximum.

Check the Professional Services Fee Schedule to see if modifier –50 is valid with the procedure performed.

Example: Bilateral Procedure

Line Item	CPT® Code/Modifier	Maximum Payment (non-facility setting)	Bilateral Policy Applied	Allowed Amount
1	64721	$ 574.30		$ 574.30 (1)
2	64721-50	$ 574.30	$ 287.15 (2)	$ 287.15
Total Allowed Amount in Non-Facility Setting:				$ 861.45 (3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a modifier –50 is always paid at 50% of the value paid for the first line item.

(3) Represents total allowable amount.

ENDOSCOPY PROCEDURES POLICY

For the purpose of these payment policies, the term, "endoscopy" will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

Payment is not allowed for an E/M office visit (CPT® codes 99201-99215) on the same day as a diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier –25 is used.

Endoscopy procedures are grouped into clinically related "families." Each endoscopy family contains a "base" procedure that is generally defined as the *diagnostic* procedure (as opposed to a *surgical* procedure).

The base procedure for each code belonging to an endoscopy family is listed in the "Endo Base" column in the Professional Services Fee Schedule. Base procedures and their family members are also identified in **Appendix A**, "Endoscopy Families."

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

1. Maximum payment for the endoscopy procedure with the highest dollar value listed in the fee schedule is 100% of the fee schedule value.

2. For subsequent endoscopy procedures, maximum payment is calculated by subtracting the fee schedule maximum for the base procedure from the fee schedule maximum for the endoscopy family member.

   When the fee schedule maximum for a family member is less than that of the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for this family member equal to $0.00 (see example #2).

3. No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an "endoscopic group." If more than one endoscopic group or other non-endoscopy procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see example #3).

Multiple endoscopies that are *not* related (e.g., each is a separate and unrelated procedure) are priced as follows:

1. 100% for each unrelated procedure, then
2. Apply the standard multiple surgery policy

Example #1: Two Endoscopy Procedures in the Same Family

Line Item	CPT® Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	*29870*	*$ 600.06*	*$ 000.00 (2)*	
1	29874	$ 803.11	$ 203.05 (4)	$ 203.05 (5)
2	29880	$ 928.88	$ 928.88 (3)	$ 928.88 (5)
			Total Allowed Amount in Non-Facility Setting:	$ 1,131.93 (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Payment is not allowed for a base code when a family member is billed.

(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(5) Amount allowed under the endoscopy policy.

(6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy does not apply because only one family of endoscopic procedures was billed.

Example #2: Endoscopy Family Member With Fee Less than Base Procedure

Line Item	CPT© Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	43235	$ 450.55		
1	43241	$ 200.02	$ 000.00 (3)	
2	43251	$ 277.81	$ 277.81 (2)	$ 277.81 (4)
Total Allowed Amount in Non-Facility Setting:				$ 277.81 (5)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.

(4) Allowed amount under the endoscopy policy.

(5) Represents total allowed amount. Standard multiple surgery policy does not apply because only one endoscopic group was billed.

Example #3: Two Surgical Procedures Billed with an Endoscopic Group

Line Item	CPT© Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	11402	$ 218.71		$ 109.36 (5)
2	11406	$ 317.71		$ 158.86 (5)
Base (1)	29830	$ 632.89		
3	29835	$ 713.71	$ 80.82 (3)	$ 80.82 (4)
4	29838	$ 822.30	$ 822.30 (2)	$ 822.30 (4)
Total Allowed Amount in Non-Facility Setting:				$ 1,171.34 (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued arthroscopy procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued arthroscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or procedure group being paid at 100%

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

MICROSURGERY

CPT® code 69990 is an "add-on" surgical code that indicates an operative microscope has been used. As an "add-on" code, it is not subject to multiple surgery rules.

CPT® code 69990 is not payable when:

- Using magnifying loupes or other corrected vision devices, or
- Use of the operative microscope is an inclusive component of the procedure, (i.e. the procedure description specifies that microsurgical techniques are used), or
- Another code describes the same procedure being done with an operative microscope. For example, CPT® code 69990 may not be billed with CPT® code 31535, operative laryngoscopy, because CPT® code 31536 describes the same procedure using an operating microscope. The table below contains a complete list of all such codes.

CPT® Codes Not Allowed with CPT® 69990

15756-15758	26551-26554	31540-31541	61548
15842	26556	31560-31561	63075-63078
19364	31520	31570-31571	64727
19368	31525-31526	43116	64820-64823
20955-20962	31530-31531	43496	65091-68850
20969-20973	31535-31536	49906	

REGISTERED NURSES AS SURGICAL ASSISTANTS

Licensed registered nurses may perform surgical assistant services if the registered nurse submits the following documents to the department or Self-Insurer along with a completed provider application.

- A photocopy of her or his valid and current registered nurse license, and
- A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is **ninety** percent (90%) of the allowed fee that would otherwise be paid to an assistant surgeon.

MISCELLANEOUS

Angioscopy

Payment for angioscopies (CPT® code 35400) is limited to only one unit based on its complete code description encompassing multiple vessels. The work involved with varying numbers of vessels was incorporated in the RVUs.

Closure of Enterostomy

Closure of enterostomy (CPT® codes 44625 and 44626) is not payable with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy (CPT® code 44139). If both are billed, only CPT® code 44139 will be paid.

ANESTHESIA SERVICES

Anesthesia payment policies are established by the department with input from the Interagency Reimbursement Steering Committee (RSC) and the Anesthesia Technical Advisory Group (ATAG). The RSC is a standing committee with representatives from the Department of Labor and Industries, the Department of Social and Health Services, and the Health Care Authority. The ATAG includes anesthesiologists, certified registered nurse anesthetists (CRNAs), and billing professionals.

NON-COVERED AND BUNDLED SERVICES

The department does not cover anesthesia assistant services.

Anesthesia is not payable for procedures that are not covered by the department. Refer to Appendix D for a list of non-covered procedures.

Patient acuity does not affect payment levels. Payment for qualifying circumstances (CPT© codes 99100, 99116, 99135 and 99140) is considered bundled and is not payable separately. CPT© physical status modifiers (-P1 to -P6) and CPT© five-digit modifiers are not accepted.

Anesthesia by surgeon (modifier -47) is not payable. Payment for local, regional or digital block or general anesthesia administered by the surgeon is considered included in the RBRVS payment for the procedure. These services will not be paid separately. Bills for anesthesia services with modifier -47 will be denied.

ANESTHESIA CODES AND MODIFIERS

Anesthesia Codes Accepted by the Department

Anesthesia services should be billed using CPT© anesthesia codes 00100 through 01999 and the appropriate anesthesia modifier.

In addition to the CPT© anesthesia codes, the department will also accept two anesthesia codes published in the American Society of Anesthesiologists' Relative Value Guide (ASARVG):

ASA Code*	ASA Description
02100	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
02101	Anesthesia for diagnostic or therapeutic nerve blocks and injections-patient in the prone position (when block or injection is performed by a different provider)

The department will not accept any other ASA codes. All other anesthesia codes should be billed according to the descriptions published in the CPT© coding book.

In 2001, the department paid for anesthesia nerve blocks using ASA codes 01961 and 01962. These code numbers have since been deleted from ASARVG and incorporated into the CPT© coding system. CPT© codes 01961 and 01962 represent anesthesia for obstetric services. When the CPT© and ASARVG code descriptions differ, providers should bill according to the CPT© descriptions.

Anesthesia Modifiers

Anesthesiologists and CRNAs should use the following modifiers when billing for anesthesia services paid with base and time units. Services billed with CPT© five-digit modifiers and physical status modifiers (-P1 through -P6) *will not be paid*. Refer to the CPT© and HCPCS books for complete modifier descriptions and instructions.

CPT© Modifiers

-23 Unusual anesthesia
Applies only to services paid with anesthesia base and time units. Services billed with this modifier may be individually reviewed prior to payment. Supporting documentation is required for this review.

-99 Multiple modifiers
This modifier should only be used when two or more modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the services performed. For billing purposes, only enter modifier -99 in the modifier column. List the individual descriptive modifiers elsewhere on the billing document.

HCPCS Modifiers

Physician Modifiers:

-AA Anesthesia services performed personally by anesthesiologist
Payment will be made to the physician using base and time units. Time is billed in total minutes.

-QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
Only physicians may use this modifier. Payment will be based on the policies for team services.

-QY Medical direction of one CRNA for a single anesthesia procedure
Only physicians may use this modifier. Payment will be based on the policies for team services.

CRNA Modifiers:

-QX CRNA service: with medical direction by a physician
Only CRNAs may use this modifier. Payment will be based on the policies for team services.

-QZ CRNA service: without medical direction by a physician
Only CRNAs may use this modifier. Payment will be made at 90% of the allowed fee that would otherwise be paid to a physician.

MEDICAL DIRECTION OF ANESTHESIA (TEAM CARE)

The department follows CMS's policy for medical direction of anesthesia, which is the same as "Team Care." Physicians directing qualified individuals performing anesthesia must:

- Perform a pre-anesthetic examination and evaluation,
- Prescribe the anesthesia plan
- Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence,

- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions,
- Monitor the course of anesthesia administration at frequent intervals,
- Remain physically present and available for immediate diagnosis and treatment of emergencies, and
- Provide indicated post-anesthesia care.

In addition, the physician may direct no more than four anesthesia services concurrently and may not perform any other services while directing the single or concurrent services. The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

The physician must document in the patient's medical record that the medical direction requirements were met. The physician does not need to submit this documentation with the bill, but must make the documentation available to the insurer upon request.

When billing for team care situations, anesthesiologists and CRNAs should submit separate bills using their own provider account numbers. Anesthesiologists billing for team care should use the appropriate modifier for medical direction or supervision (-QK or -QY). CRNAs billing for team care should use modifier -QX. Once the total maximum anesthesia payment is calculated, 50% of that amount may be paid to the physician, and 45% to the CRNA (90% of the other 50% share).

CERTIFIED REGISTERED NURSE ANESTHETISTS

Licensed nursing rules and billing instructions are contained in WACs 296-23-240 and –245. CRNA services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician. The only modifiers that are valid for CRNAs are -QX and -QZ.

Billing Tip

CRNA services must be billed on a separate HCFA-1500 form from those of an anesthesiologist. This applies to CRNAs providing solo services as well as team care. More information and examples of how to submit bills can be found in the department's HCFA-1500 billing instructions (publication #F248-094-000).

ANESTHESIA SERVICES PAID WITH BASE AND TIME UNITS

Most anesthesia services are paid with base and time units. The department's anesthesia base units are adapted from CMS's anesthesia base units with input from the Anesthesia Technical Advisory Group (ATAG). The anesthesia codes and base units are listed in the Professional Services Fee Schedule.

Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent). Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e. when the patient can be safely placed under postoperative supervision). Anesthesia should be billed in *one-minute* time units.

Billing Tip

List only the time *in minutes* on your bill. Do not include the base units. The appropriate base units will be automatically added by the department's payment system when the bill is processed.

Anesthesia Payment Calculation

The maximum payment for anesthesia services paid with base and time units is calculated using the base value for the procedure, the time the anesthesia service is administered, and the department's anesthesia conversion factor. The anesthesia conversion factor is published in WAC 296-20-135. For services provided on or after July 1, 2002, the anesthesia conversion factor is $41.70 per 15 minutes ($2.78 per minute). Providers are paid the lesser of their charged amount or the department's maximum allowed amount.

To determine the maximum anesthesia payment for a procedure:

1. Multiply the base units listed in the fee schedule by fifteen.
2. Add the value from step 1 to the total number of whole minutes.
3. Multiply the result from step 2 by $2.78.

Example:

CPT® code 01382 (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum payment would be calculated as follows:

1. Base units x 15 = 3 x 15 = 45 base units
2. 45 base units + 60 time units (minutes) = 105 base and time units.
3. Maximum Payment = 105 x $2.78 = $ 291.90

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes should be billed with a primary anesthesia code. There are three anesthesia add-on codes in the 2002 CPT® book: 01953, 01968 and 01969. CPT® add-on code 01953 should be billed with primary code 01952. CPT® add-on codes 01968 and 01969 should be billed with primary code 01967.

Anesthesia add-on codes 01968 and 01969 should be billed in the same manner as other anesthesia codes paid with base and time units. Providers should report the total time for the add-on procedure (in minutes) in the "Units" column (Field 24G) of the HCFA-1500 form.

Anesthesia for Burn Excisions or Debridement

The anesthesia add-on code for burn excision or debridement, CPT® code 01953, should be billed according to the instructions in the following table.

Total Body Surface Area	Primary Code	Units of Add-On Code 01953
Less than 1 percent	01951	None
1 - 9 percent	01952	None
Up to 18 percent	01952	1
Up to 27 percent	01952	2
Up to 36 percent	01952	3
Up to 45 percent	01952	4
Up to 54 percent	01952	5
Up to 63 percent	01952	6
Up to 72 percent	01952	7
Up to 81 percent	01952	8
Up to 90 percent	01952	9
Up to 99 percent	01952	10

ANESTHESIA SERVICES PAID WITH RBRVS

Some services commonly performed by anesthesiologists and CRNAs are *not* paid with anesthesia base and time units. These services include code 01996, most pain management services and other selected services. These services are paid with the Washington RBRVS fee schedule and are listed in Appendix F.

No anesthesia modifiers should be used when billing for services payable under RBRVS; if an anesthesia modifier is used, the payment for that code will be denied. Payment rates for codes payable under RBRVS are located in the Professional Services Fee Schedule.

Billing Tip

When services are billed under RBRVS, the total number of times the procedure is performed, not the total minutes, should be entered in the "Units" column (Field 24G) on the HCFA-1500 bill form.

E/M Services Payable with Pain Management Procedures

An evaluation and management service is payable on the same day as a pain management procedure *only when*:

- It is the patient's *initial visit* to the practitioner who is performing the procedure or
- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service.

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action. The use of E/M codes on days after the procedure is performed is subject to the global surgery policy (refer to "Surgery Services" section).

Injection Code Treatment Limits

Details regarding treatment guidelines and limits for the following kinds of injections can also be found in WAC 296-20-03001. Refer to "Medication Administration" in the "Other Medicine Services" section for information on billing for medications.

Injection	Treatment Limit
Epidural and caudal injections of substances other than anesthetic or contrast solution	*Maximum of six* injections per acute episode are allowed.
Facet injections	*Maximum of four* injection procedures per patient are allowed.
Intramuscular and trigger point injections of steroids and other non-scheduled medications and trigger point *dry needling**	*Maximum of six* injections per patient are allowed.

* Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services (WAC 296-20-03002). Dry needling of trigger points should be billed using trigger point injection codes 20552 or 20553. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).